DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: EPSDT Clinics
Managed Care Plans
CSO Administrators
Regional Administrators

Memorandum No: 03-29 MAA
Issued: June 16, 2003

For Information Call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Supersedes: 02-26 MAA

Subject: EPSDT Clinics: Fee Schedule Changes and Discontinued State-Unique Procedure Codes

Effective for dates of service on and after July 1, 2003, the Medical Assistance Administration (MAA) will:

- Implement the updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2003 relative value units (RVUs);
- Implement the updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- Implement the Year 2003 additions of Current Procedural Terminology (CPT™) codes;
- Implement the additions to Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes; **AND**
- **Discontinue** all state-unique procedure codes previously used in the EPSDT Program Billing Instructions.

Maximum Allowable Fees

MAA is updating the fee schedule with Year 2003 RVUs and clinical laboratory fees. The 2003 Washington State Legislature **has not appropriated a vendor rate increase** for the 2004 state fiscal year. The maximum allowable fees have been adjusted to reflect the changes listed above.

Overview

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. In order to comply with HIPAA requirements, MAA is discontinuing all state-unique procedure codes and modifiers and will require the use of applicable CPT™ and HCPCS procedure codes.

Discontinued State-Unique Interperiodic Code

MAA currently requires the **state-unique procedure code 0252M** to identify an interperiodic screening. **Effective for claims with dates of service after June 30, 2003, this code will be discontinued.**

Providers **must use** the appropriate CPT Evaluation and Management (E&M) code from the range **99201-99215 with the modifier -EP** to identify suspected health problems if regular screenings have already been conducted for the year.

Modifier –EP:	Services provided as part of Medicaid EPSDT program

In addition, when an immunization is the only service performed, and the vaccine **is not** available free of charge from the Department of Health (DOH), the provider may bill a CPT immunization administration code in addition to the vaccine drug code. If the vaccine **is** available free of charge from DOH, the provider must bill MAA the vaccine drug code with the modifier –SL. MAA will reimburse the provider an administration fee.

☞ **NOTE:** If the provider is using the mother's PIC code to bill E&M codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider **must use modifier -HA** in order to be reimbursed the higher rate for children's services. **Modifier -HA must be the FIRST modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

Attached are replacement pages C.3/C.4 and E.3-E.10 for MAA's EPSDT Billing Instructions, dated July 2001. To obtain this fee schedule electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

Bill MAA your usual and customary charge.

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For clients who are…	Must be scheduled within…
Managed Care plans or Primary Care Providers (PCPs)	Infants - within the first 2 years of life.	Within 21 days of request
	Children - two years and older.	Within six weeks of request.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	0 through 20 years of age	Within 14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

EPSDT Interperiodic Screenings

EPSDT providers can bill an evaluation and management (E&M) procedure code (CPT codes 99201-99215) **with the modifier -EP** to identify suspected health problems if regular screenings have already been conducted for the year. Use the ICD diagnosis code that most accurately reflects the reason for the client's visit.

Modifier –EP: Services provided as part of Medicaid EPSDT program

In addition, when an immunization is the only service performed, and the vaccine **is not** available free of charge from the Department of Health (DOH), the provider may bill a CPT immunization administration code in addition to the vaccine drug code. If the vaccine **is** available free of charge from DOH, the provider must bill MAA the vaccine drug code with the modifier –SL. MAA will reimburse the provider an administration fee.

NOTE: If the provider is using the mother's PIC code to bill E&M codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider **must use modifier -HA** in order to be reimbursed the higher rate for children's services. **Modifier -HA must be the FIRST modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

What if a medical problem is identified during a screening examination?

If a medical problem is identified during a screening examination, the provider may:

- Provide the service for the client (if it is within the provider's scope of practice); or
- Refer the client to an appropriate provider for medical treatment.

Referrals

Medical Nutrition Therapy

(formerly known as "Nutritional Counseling")

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral. You should inform the client or the client's parent(s) or guardian(s) of the importance of oral/dental health and recommend that the client be seen by a dentist as follows:

- Yearly, or sooner if a problem is suspected.

  Note: Unless a problem is suspected earlier, the child should be at least 1 year of age and have his/her first tooth and has not been examined by a dentist within the past year.

Orthodontics

Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. MAA covers orthodontics for children with cleft lip or palates or severe handicapping maloclussions only. You must obtain prior authorization from MAA before providing orthodontic services. MAA does not cover orthodontic treatment for other conditions.

Third party liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different than MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA; and
- Attach the insurance carrier's statement.

If you are rebilling, also attach a copy of the MAA *Remittance and Status Report* showing the previous denial.

If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the **Comments** field of the Electronic Media Claim (EMC).

Third-party carrier codes are available via the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

Fee Schedule

EPSDT Screenings

Note: Make certain the procedure code you use corresponds correctly to the age of the child receiving the EPSDT services.

Use the PIC of either parent for a newborn if the baby has not yet been issued a PIC. Enter indicator **B** in *field 19* of the HCFA-1500 claim form to indicate that the baby is using a parent's PIC. When using a parent's PIC for twins or triplets, etc., identify each baby separately (i.e., twin A, twin B) using a *separate HCFA-1500 claim form* for each. **Note: The parents' Healthy Options Plan is responsible for providing medical coverage for the newborn.**

Foster Care Children: MAA reimburses appropriate providers an enhanced, flat fee of $120.00 per EPSDT screen for foster care children. This applies to CPT™ codes 99381-99385 and 99391-99395 only. To receive the enhanced rate, providers **must** include modifier 21 in field 24D on the HCFA-1500 claim form to identify the child as a foster care child.

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT® procedure code descriptions. To view the full descriptions, refer to your current CPT® book.

New Patient

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee		
		NFS Fee	FS Fee	Foster Care
99381	Prev visit, new, infant	$59.39	$36.07	$120.00
99382	Prev visit, new, age 1-4	68.60	44.42	120.00
99383	Prev visit, new, age 5-11	77.82	51.43	120.00
99384	Prev visit new, age 12-17	82.41	56.69	120.00
99385	Prev visit, new, age 18-20	87.01	59.85	120.00

Established Patient

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee		
		NFS Fee	FS Fee	Foster Care
99391	Prev visit, est. infant	$46.03	$32.02	$120.00
99392	Prev visit, est, age 1-4	55.25	39.77	120.00
99393	Prev visit, est, age 5-11	63.99	46.67	120.00
99394	Prev visit, est, age 12-17	68.60	51.59	120.00
99395	Prev visit, est, age 18-20	73.21	54.41	120.00

The appropriate diagnosis code is required when billing the above EPSDT screening CPT® codes 99381-99395.

Interperiodic Screenings

Procedure Code/Mod	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
99201 – EP	Office/outpatient visit, new	$33.84	$22.08
99202 – EP	Office/outpatient visit, new	60.20	43.81
99203 – EP	Office/outpatient visit, new	89.05	66.97
99204 – EP	Office/outpatient visit, new	126.81	99.02
99205 – EP	Office/outpatient visit, new	161.71	131.79
99211 – EP	Office/outpatient visit, est	19.95	8.55
99212 – EP	Office/outpatient visit, est	35.26	22.08
99213 – EP	Office/outpatient visit, est	49.16	33.13
99214 – EP	Office/outpatient visit, est	76.94	54.14
99215 - EP	Office/outpatient visit, est	112.56	87.27

Laboratory Services

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
36415	Drawing blood	$2.45	$2.45
81000	Urinalysis, nonauto w/scope	3.59	3.59
81001	Urinalysis, auto w/scope	3.59	3.59
81002	Urinalysis, nonauto w/o scope	2.89	2.89
81003	Urinalysis, auto, w/o scope	2.54	2.54
81005	Urinalysis	2.45	2.45
81007	Urine screen for bacteria	2.91	2.91
81015	Microscopic exam of urine	3.43	3.43
81025	Urine pregnancy test	4.25	4.25
81050	Urinalysis, volume measure	3.39	3.39
81099	Urinalysis test procedure	B.R.	B.R.
82135	Assay, aminolevulinic acid	18.63	18.63
83655	Assay of lead	13.70	13.70
84035	Assay of phenylketones	2.38	2.38
84202	Assay RBC protoporphyrin	16.24	16.24
84203	Test RBC protoporphyrin	9.74	9.74
85013	Hematocrit	2.68	2.68
85014	Hematocrit	2.68	2.68
85018	Hemoglobin	2.68	2.68
86580	TB intradermal test	6.14	6.14
86585	TB tine test	4.78	4.78

Immunizations

The following procedure codes must be used to bill for the administration of immunizations:

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
90471	Immunization admin	$5.00	$5.00
90472	Immunization admin, each add	$3.00	$3.00

Immunizations for EPSDT are usually given in conjunction with a screening or interperiodic screening. Do not bill an Evaluation and Management (E&M) code unless there is a separate, identifiable diagnosis that is different from the immunization.

- MAA will reimburse an administration fee (up to $5.00) for vaccines available through the state's Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under. When immunization materials are received from the Department of Health, you must bill the appropriate procedure code with **modifier –SL** (e.g., 90700-SL). **In the following list, the procedure codes that are shaded identify these vaccines. Do not bill CPT codes 90471 and 90472.**

- Do not bill with modifier -SL for any of the procedure codes listed on the following page if the client is 19 through 20 years of age, or if the procedure code is NOT shaded.

- Bill 90471 and 90472 with the vaccine or toxoid procedure code.

- Do not bill administration codes 90471 and 90472:
  - ✓ As multiple units; or
  - ✓ More than once per day, per client.

- Bill only CPT code 90471 when administering one vaccine. Bill both CPT codes 90471 and 90472 with one unit per code when administering more than one vaccine. MAA will reimburse a maximum of $8.00 when:

  - ✓ More than one vaccine is administered; and,
  - ✓ Both CPT codes 90471 and 90472 are billed; and,
  - ✓ Those vaccines are not available through the Universal Vaccine Distribution Program or Federal Vaccines for Children Program.

- When an immunization is the only service performed, and the vaccine **is not** available free of charge from the Department of Health (DOH), the provider may bill a CPT immunization administration code in addition to the vaccine drug code. If the vaccine **is** available free of charge from DOH, the provider must bill MAA the vaccine drug code with the modifier –SL. MAA will reimburse the provider an administration fee.

- Reimbursement rates for immunization materials include federal excise tax.

Immunization Fees

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
90476	Adenovirus vaccine, type 4	Not covered	Not covered
90477	Adenovirus vaccine , type 7	Not covered	Not covered
90581	Anthrax vaccine, sc	Not covered	Not covered
90585	Bcg vaccine, percut	$144.96	$144.96
90586	Bcg vaccine, intravesical	144.96	144.96
90632	Hep a vaccine, adult im	55.27	55.27
90633	Hep a vacc, ped/adol, 2 dose	26.98	26.98
90634	Hep a vacc, ped/adol, 3 dose	Not covered	Not covered
90636	Hep a/hep b vacc, adult im	84.41	84.41
90645	Hib vaccine, hboc, im	22.02	22.02
90646	Hib vaccine, prp-d, im	18.41	18.41
90647	Hib vaccine, prp-omp, im	15.90	15.90
90648	Hib vaccine, prp-t, im	20.84	20.84
90657	Flu vaccine, 6-35 mo, im	2.59	2.59
90658	Flu vaccine, 3 yrs, im	4.04	4.04
90659	Flu vaccine, whole, im	2.59	2.59
90660	Flu vaccine, nasal	Not covered	Not covered
90665	Lyme disease vaccine, im	55.31	55.31
90669	Pneumococcal vacc, ped<5	65.47	65.47
90675	Rabies vaccine, im	123.26	123.26
90676	Rabies vaccine, id	77.94	77.94
90680	Rotovirus vace, oral	Not covered	Not covered
90690	Typhoid vaccine, oral	9.21	9.21
90691	Typhoid vaccine, im	38.02	38.02
90692	Typhoid vaccine, h-p, sc/id	1.01	1.01
90693	Typhoid vaccine, akd, sc	Not covered	Not covered
90700	Dtap vaccine, im	20.29	20.29
90701	Dtp vaccine, im	9.52	9.52
90702	Dt vaccine <7, im	3.26	3.26
90703	Tetanus vaccine, im	13.01	13.01
90704	Mumps vaccine, sc	16.16	16.16
90705	Measles vaccine, sc	13.04	13.04
90706	Rubella vaccine, sc	15.15	15.15
90707	Mmr vaccine, sc	36.85	36.85
90708	Measles-rubella vaccine, sc	21.81	21.81
90710	Mmrv vaccine, sc	Not covered	Not covered
90712	Oral poliovirus vaccine	17.59	17.59

CORRECTED ONLINE 10/16/03

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
90713	Poliovirus, ipv, sc	$23.27	$23.27
90716	Chicken pox vaccine, sc	62.31	62.31
90717	Yellow fever vaccine, sc	53.56	53.56
90718	Td vaccine >7, im	10.43	10.43
90719	Diphtheria vaccine, im	Not covered	Not covered
90720	Dtp/hib vaccine, im	34.03	34.03
90721	Dtp/hib vaccine, im	Not covered	Not covered
90725	Cholera vaccine, injectable	2.78	2.78
90732	Pneumococcal vacc, adult/ill	11.86	11.86
90733	Meningococcal vaccine, sc	59.35	59.35
90735	Encephalitis vaccine, sc	72.20	72.20
90740	Hepb vacc, ill pat 3 dose im	100.41	100.41
90743	Heb b vacc, adol, 2 dose, im	24.49	24.49
90744	Hepb vacc ped/adol 3 dose, im	24.49	24.49
90746	Hep b vaccine, adult, im	50.21	50.21
90747	Hepb vacc, ill pat 4 dose, im	100.41	100.41
90748	Heb b/hib vaccine, im	92.02	92.02
90749	Vaccine toxoid	By Report	By Report

Injectable Drugs (J-Codes)

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
J0850	Cytomegalovirus imm IV / vial	$635.79	$635.79
J1460	Gamma globulin 1 CC inj	10.32	10.32
J1470	Gamma globulin 2 CC inj	20.64	20.64
J1480	Gamma globulin 3 CC inj	31.00	31.00
J1490	Gamma globulin 4 CC inj	41.28	41.28
J1500	Gamma globulin 5 CC inj	51.60	51.60
J1510	Gamma globulin 6 CC inj	61.80	61.80
J1520	Gamma globulin 7 CC inj	72.17	72.17
J1530	Gamma globulin 8 CC inj	82.56	82.56
J1540	Gamma globulin 9 CC inj	92.97	92.97
J1550	Gamma globulin 10 CC inj	103.20	103.20
J1560	Gamma globulin > 10 CC inj (per cc)	10.32	10.32
J1563	IV immune globulin	70.95	70.95
J1564	Immune globulin 10 mg	0.78	0.78

CORRECTED ONLINE 10/16/03

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
J1565	RSV-ivig	$14.98	$14.98
J1670	Tetanus immune globulin inj	107.50	107.50
J2790	Rho d immune globulin inj	90.82	90.82
J2792	Rho(D) immune globulin h, sd	18.60	18.60
90780	IV infusion therapy, 1 hour	26.39	26.39
90781	IV infusion, additional hour	13.42	13.42
90782	Injection, sc, im	2.73	2.73
90783	Injection, ia	9.78	9.78
90784	Injection, iv	11.38	11.38

Immune Globulins

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
90281	Human ig, im	Not covered	Not covered
90283	Human ig, iv	Not covered	Not covered
90287	Botulinum antitoxin	Not covered	Not covered
90288	Botulism ig, iv	Not covered	Not covered
90291	Cmv ig, iv	Not covered	Not covered
90296	Diphtheria antitoxin	Not covered	Not covered
90371	Hep b ig, im	$143.18	$143.18
90375	Rabies ig, im/sc	65.95	65.95
90376	Rabies ig, heat treated	70.71	70.71
90378	Rsv ig, im, 50 mg **(Requires prior authorization)** Rsv ig, im, 100 mg **(Requires prior authorization)** Rsv ig, im, 150 mg **(Requires prior authorization)** Rsv ig, im, 200 mg **(Requires prior authorization)**	$598.00 970.00 1,568.00 1,940.00	$598.00 970.00 1,568.00 1,940.00
90379	Rsv ig, iv	Not covered	Not covered
90384	Rh ig, full-dose, im	Not covered	Not covered
90385	Rh ig, minidose, im	Not covered	Not covered
90386	Rh ig, iv	Not covered	Not covered
90389	Tetanus ig, im	Not covered	Not covered
90393	Vaccina ig, im	Not covered	Not covered
90396	Varicella-zoster ig, im	95.68	95.68
90399	Immune globulin	Not covered	Not covered

Audiologic Function Tests

The audiometric tests listed below imply the use of calibrated electronic equipment. Other hearing tests are considered part of the general otorhinolaryngologic services and are not billed separately.

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
92552	Pure tone audiometry, air	$10.92	$10.92
92553	Audiometry, air & bone	16.15	16.15

Fluoride Varnish Applications

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
D1203	Topical fluor w/o prophy chi	$13.39	$13.39